Instructions for Completing the 1994 ADA Dental Claim Form

The most important box on the Dental Claim Form is Box 1, Provider ID #. A dental claim cannot be accepted, nor can payment be made, without a correct provider number. Provider number means the twelve (12) digit Provider Identification Number assigned by Medicaid.

In addition to Box 1, certain other boxes must be completed when submitting the form either for a Prior Authorization request or for payment. These required boxes have an asterisk (*) beside a field number and are in **bold prin**t. If a required field is not completed, the claim will be denied. The double asterisk (**) beside a number indicates a field which is required only in specific situations. All other fields are not required.

***Box 1.** Attending Dentist's statement: Check only one of the two following statements: To request Prior Authorization, check "Dentist's pre-treatment estimate." To request payment, check "Dentist's statement of actual services."

Enter the dentist's twelve (12) digit Utah Medicaid Provider Identification Number in Box 1. Do not use Box 24 for the provider number.

***Box 2.** Check one of the following:
Medicaid Claim
EPSDT
***Prior Authorization #:** When prior authorization is required, enter the seven (7) digit Medicaid Prior Authorization number or the seven (7) digit MI-706 number issued by UMAP.

***Patient ID #:** Enter the patient's Medicaid Identification Number (ID) as found on the Medicaid Identification Card, MI-706 Form or Interim Verification of Medical Eligibility (Form 695).

***Box 3.** Carrier name and address: Enter the Medicaid street address here.

***Box 4.** Patient Name (first, m.i., last): Enter the first name, middle initial and last name of patient exactly as it is printed on the Medicaid Identification Card, the Interim Verification of Eligibility Form (Form 695), or MI-706 Form, Utah Medical Assistance Reimbursement Agreement.

Box 5. Relationship to employee: Not required.

Box 6. Sex: Indicate gender of patient. Not required.

****Box 7.** Patient birthdate: [Desirable on prior authorization, not required on dentist's statement of actual services.] Enter the exact birth date as it appears on the Medicaid Identification Card, the Interim Verification of Eligibility Form (Form 695), or MI-706 Form, Utah Medical Assistance Reimbursement Agreement. Enter date as 6 digits: MMDDYY: two digits for the month (MM), two digits for the day (DD), and two digits for the year (YY). Example: enter April 1, 1950 as "040150."

Box 8. If full time student school: Not required.

Box 9. Employee/subscriber name and mailing address: Not required.

Box 10. Employee/subscriber dental plan ID number: Not required.

Box 11. Employee/subscriber birth date: Not required.

Box 12. Employer (company) name and address: Not required.

Box 13. Group number: Not required.

****Box 14.** Is patient covered by another dental plan?: If the patient is covered by a plan OTHER THAN Medicaid, Medicare, or UMAP, enter "yes" on the dental and/or medical lines (15a & 15b) as appropriate.

****Box 15a.** Name and address of carrier(s): Enter the name of the carrier(s). The address is not required.

****Box 15b.** Group no.(s): Enter the patient's group number.

Box 16. Name and address of other employer(s): Not required.

Box 17a. Employee/subscriber name: Not required.

Box 17b. Employee/subscriber dental plan I.D. number: Not required.

Box 17c. Employee/subscriber birthdate: Not required.

Box 18. Relationship to patient: Not required.

Box 19. Signed (Patient)/Date: Not required.

Box 20. Signed (Employee/subscriber)/Date: Not required.

***Box 21.** Name of billing dentist or Dental entity: Enter the name of the dentist.

***Box 22.** Remittance address: Enter the complete street address.

***Box 23.** City, State, Zip: Enter the city, state & zip code for the remittance address.

Box 24. Dentist Soc. Sec. or T.I.N.: Not required.

Box 25. Dentist license no.: Not required.

Box 26. Dentist phone no.: Not required.

Box 27. First visit date current series: Not required.

***Box 28.** Place of treatment: Check the box for Office, Hospital, Extended Care Facility (i.e. nursing home), or Other.

****Box 29**. Radiographs or models enclosed: Enclose radiographs ONLY if the form is being submitted for Prior Authorization. DO NOT submit radiographs with the statement of actual services sent for payment purposes.

***Box 30.** Is the treatment result of occupational illness or injury? Check Yes or No.

***Box 31.** Is the treatment result of auto accident?: Check Yes or No.

***Box 32.** Other accident?: Check Yes or No.

Box 33. If prosthesis, is this initial placement?: Not required.

Box 34. Date of prior placement: Not required.

Box 35. Is treatment for orthodontics?: Not required.

Box 36. Identify missing teeth with “x”: Not required.

***Box 37.** Examination and treatment plan: Do not exceed eighteen (18) lines per form. It is not required that the tooth numbers be listed in numerical or alphabetical order.

***Tooth # or letter**: Complete this item giving the tooth number or letter.

***Surface:** Complete this item giving the surface identification as shown below:

M = Mesial
B = Buccal
D = Distal
O = Occlusal
L = Lingual
I = Incisal
F = Facial

****Description of Service:** [Desirable] Give a narrative description of the service provided, including x-rays, prophylaxis, materials, etc.

***Date service performed:** Enter date in MMDDYY format.

***Procedure number:** Enter the Medicaid procedure code for the service rendered. All Medicaid procedure codes begin with a "D" or a "Y". Medicaid procedure codes are listed in SECTION 2 of the Dental Manual, Chapter 5. ADA code numbers not listed are not covered services and will not pay when prefixed by a "D".

***Fee:** Enter your usual and customary fee. Medicaid uses the usual and customary fees submitted to determine future reimbursement levels and budget requests to the Legislature.

Box 38. Remarks for unusual services: Not required.

Box 39. Signed (Treating Dentist): Signature of the dentist is not required. License number not required.

***Date:** Enter the billing date or prior authorization request date. If this is the dentist's statement of actual services, the date must be equal to or later than the last date of service in box 37.

Box 40. Address where treatment was performed: Not required.

***Box 41.** Total Fee Charged: Enter the total of all line item fees.

****Box 42.** Payment by other plan: Enter any amount paid by other plan.

Instructions for Completing ADA Dental Claim Form 1999 Version 2000

The most important box on the Dental Claim Form is Box 44, Provider ID #. A dental claim cannot be accepted, nor can payment be made, without a correct provider number. Provider number means the twelve (12) digit Provider Identification Number assigned by Medicaid.

In addition to Box 44, certain other boxes must be completed when submitting the form either for a Prior Authorization request or for payment. These required boxes have an asterisk (*) beside a field number and are in **bold print**. If a required field is not completed, the claim will be denied. The double asterisk (**) beside a number indicates a field which is required only in specific situations. All other fields are not required.

Attending Dentist's statement: Check only one of the two following statements:

***Box 1.** To request Prior Authorization, check "Dentist' pre-treatment estimate"
To request payment, check "Dentist's statement of actual services"

***Box 2.** Check one of the following:
Medicaid Claim
EPSDT

***Prior Authorization #:** When prior authorization is required, enter the seven (7) digit Medicaid Prior Authorization number or the seven (7) digit MI-706 number issued by UMAP directly below "Prior Authorization #".

Box 3. Carrier name: Not required.

Box 4. Carrier Address: Not required.

Box 5. City: Not required.

Box 6. State: Not required.

Box 7. Zip: Not required.

***Box 8.** Patient Name (last, first, middle): Enter the last name, first name, and middle name of patient exactly as it is printed on the Medicaid Identification Card, the Interim Verification of Eligibility Form (Form 695), or MI-706 Form, Utah Medical Assistance Reimbursement Agreement.

Box 9. Address: Not required.

Box 10. City: Not required.

Box 11. State: Not required.

***Box 12.** Date Of Birth: [Desirable on prior authorization; not required on dentist's statement of actual services] Enter the exact birth date on the Medicaid Identification Card, the Interim Verification of Eligibility Form (Form 695), or MI-706 Form, Utah Medical Assistance Reimbursement Agreement. Enter date as 6 digits: MMDDYY: two digits for the month (MM), two digits for the day (DD), and two digits for the year (YY). Example: enter April 1, 1950 as "040150."

Box 13. Patient ID#: Not required.

Box 14. Sex: Not required.

Box 15. Phone number: Not required.

Box 16. Zip Code: Not required.

Box 17. Relationship to Subscriber/Employee: Not required.

Box 18. Employer/School: Not required.

***Box 19.** Subs/Emp. ID#/SSN#: Enter the patient's Medicaid Identification Number (ID) as found on the Medicaid Identification Card, MI-706 Form or Interim Verification of Medical Eligibility (Form 695).

Box 20. Employer Name: Not required.

Box 21. Group #: Not required.

Box 22. Subscriber/Employee Name (Last, First, Middle): Not required.

Box 23. Address: Not required.

Box 24. Phone Number: Not required.

Box 25. City: Not required.

Box 26. State: Not required.

Box 27. Zip Code: Not required.

Box 28. Date of Birth: Not required.

Box 29. Marital Status: Not required.

Box 30. Sex: Not required.

***Box 31.** Is Patient covered by another plan? Check the box "yes" or "no" as applicable.

****Box 32.** Policy #: Enter policy number of other insurance.

Box 33. Other subscribers name: Not required.

Box 34. Date of Birth: Not required.

Box 35. Sex: Not required.

Box 36. Plan/Program name: Not required.

Box 37. Employer/School: Not required.

Box 38. Subscriber/Employee Status: Not required.

Box 39. Release of Information: Not required.

Box 40. Employer/School: Not required. Box 41. Authorization of Payment: Not required.

***Box 42.** Name of Billing Dentist or Dental Entity: Enter the name of the billing dentist.

****Box 43.** Phone Number: optional.

***Box 44. Provider ID #: Enter the dentist's twelve (12) digit Utah Medicaid Provider Identification Number.**

Box 45. Dentist Soc. Sec. Or T.I.N. : Not required.

***Box 46.** Address: Enter the complete street address of the billing dentist.

Box 47. Dentist License #: Not required.

Box 48. First visit date of current series: Not required.

***Box 49.** Place of Treatment: Check the box for Office, Hospital, Extended Care Facility (i.e. nursing home), or Other as applicable.

***Box 50**. City: Enter city of billing dentist.

***Box 51.** State: Enter state of billing dentist.

***Box 52.** Zip Code: Enter zip code of billing dentist.

****Box 53.** Radiographs or models enclosed?: Enclose radiographs ONLY if the form is being submitted for Prior Authorization. DO NOT submit radiographs with the statement of actual services sent in for payment purposes.

Box 54. Treatment for Orthodontia?: Not required.

Box 55. If prosthesis (crown, bridge, dentures,) is this initial placement?: Not required.

Box 56. Is treatment result of occupational illness or injury?: Not required.

***Box 57.** Is Treatment result of auto accident, other accident or neither?: Check box as applicable.

Box 58. Diagnosis Code Index: Not required.

***Box 59.** Examination and Treatment plans:

*__Date:__ Enter date in MMDDYY format. Enter date as six (6) digits: MMDDYY: two digits for the month (MM), two digits for the day (DD), and two digits for the year (YY). Example: enter April 1, 1950 as "040150."

***Tooth:** Complete this item giving the tooth number or letter.

***Surface:** Complete this item giving the surface identification as shown below:

M = Mesial
B = Buccal
D = Distal
O = Occlusal
L = Lingual
I = Incisal
F = Facial

Diagnosis Index #: Not required.

***Procedure Code:** Enter the Medicaid procedure code for the service rendered. All Medicaid procedure codes begin with a "D" or a "Y". Medicaid procedure codes are listed in SECTION 2 of the Dental Manual, Chapter 5. ADA code numbers not listed are not covered services and will not pay when prefixed by a "D".

*__Qty:__ Enter quantity. Minimum quantity is 1 and total quantity should not exceed 18 per claim.

****Description of Service:** [Desirable] Provide a narrative description of the service provided, including x-rays, prophylaxis, materials, etc.

***Fee:** Enter your usual and customary fee. Medicaid uses the usual and customary fees submitted to determine future reimbursement levels and budget requests to the Legislature.

*__Total Fee:__ Enter the total of all line item fees.

*__Payment by other plan:__ Enter any Third Party Liability/ payment amounts.

Box 60. Identify all missing teeth with "X": Not required.

Box 61. Remarks for unusual services: Not required.

Box 62. Signed (Treating Dentist): Not required.

***Date:** Enter the billing date. If this is the dentist's statement of actual services, the date must be equal to or greater than the last date of service in box 59.

Box 63. Address where treatment was performed: Not required.

Box 64. City: Not required.

Box 65. State: Not required.

Box 66. Zip Code: Not required.